STATE OF LOUISIANA
DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
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CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Family and Medical Leave Act of 1993)

The information provided should only relate to the condition for which FMLA is being requested.

1. Employee's Name _____

2. Patient's Name (if other than employee) _____

3. A "*Serious Health Condition" means an illness, injury, impairment, or physical or mental condition in one of the following categories: (Please check applicable category).
*The attached sheet describes what is meant by a serious health condition under the Family and Medical Leave Act.

_____ hospital care _____absence plus treatment _____ pregnancy

_____ chronic conditions requiring treatments _____ permanent/long term conditions requiring supervision _____ multiple treatments (non-chronic conditions)

_____ other: explain: _____

4. If the patient's condition qualified under one of the above categories, describe medical facts which support your certification and explain how your findings meet the criteria of that category?
_____
_____
_____

5. Give approximate date on which the condition commenced, probable duration of the condition, and include probable duration of patient's present incapacity if different. _____
_____
_____
_____

6. Where additional treatments are required for the condition, state probable number of treatments. ("Treatments" for purposes of FMLA, includes examinations to determine if a serious health condition exists and evaluations of the condition). _____
_____
_____
_____

7. If any treatments are to be administered by another health care provider, state the nature of the treatments:
_____
_____
_____

8. If a patient must undergo a regiment of continuing treatment under your supervision, give a general overview of the regimen (e.g. prescription drugs, physical therapy requiring special equipment).
_____
_____
_____

IF THIS CERTIFICATE RELATES TO THE CARE OF THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 9, 10, 11, AND 12, AND PROCEED TO ITEMS 13 THROUGH 15.

9. Does the employee need to be off work intermittently or work less than a full work schedule due to his/her condition? _____ If yes, give probable duration. _____

10. Is the condition a chronic condition or pregnancy and if so, is the patient incapacitated or will the patient become incapacitated? ("Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery there from).
_____
_____
_____

If yes, give the approximate duration and frequency of period of incapacity. _____
_____
_____

11. Will it be necessary for the employee to be absent from work for treatment? _____

12. When an employee requests medical leave due to absence from work for his/her own condition (including absences due to pregnancy or a chronic condition), is the employee able to perform the essential functions of his/her position? (Answer after reviewing statement from employer of essential functions of employee's position, or if not provided, after discussing with employee).
_____
_____

If yes, list the essential functions of the job that the employee is able to perform. _____
_____
_____

If no, list the essential functions of the job that the employee is unable to perform. _____
_____
_____

TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER

13. When an employee requests leave to are for a family member with a serious health condition, does (or will) the patient require assistance for basic medical or personal needs or safety, or for transportation? _____
_____
_____

14. If the employee's presence is not required as stated in Item 13, would his/her presence provide psychological comfort beneficial to the patient or assist in the patient's recovery?_____
_____

Estimate the period of time care is needed or the employee's presence would be beneficial to the patient._____
_____

15. When family leave is needed to care for a family member with a serious health condition, state the care you will provide, estimate the time period which this care will be provided, and include a schedule if leave is to be taken intermittently or on a reduced leave schedule.
_____
_____
_____

_____ _____
Employee Signature Date

_____ _____
Signature of Health Care Provider Date

_____ _____
Type of Practice Area Code and Telephone Number